

## MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM (form effective 1/3/2022)

Prior authorization guidelines for **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request	Renewal request	# of pages:	Prescriber name:				
Name of office contact:			Specialty:				
Contact's phone number:			NPI:		State license #:		
LTC facility contact/phone:			Street address:				
Beneficiary name:			Suite #: City/state/zip:				
Beneficiary ID#:		DOB:	Phone:		Fax:		
CLINICAL INFORMATION							
Drug requested:			Strength:	Benefic	Beneficiary's weight:		
Directions:				Quantit	y:	Refills:	
Diagnosis (submit documentation):				Dx cod	Dx code ( <u>required</u> ):		
Has the beneficiary been receiving treatment with the requested medication?				□Yes	☐Yes – Submit documentation. ☐No		
INITIAL requests							
For a non-preferred Multiple Sclerosis Agent: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred drugs in this class.					entation.		
Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.							
☐ Has a relapsing form of MS (specify) → ☐ clinically isolated syndrome ☐ relapsing remitting disease ☐ active secondary progressive disease ☐ Has primary progressive MS							
Request is for AMPYRA/DALFAMPRIDINE:  Has motor dysfunction on a continuous basis that impairs the ability to complete activities of daily living (ADLs) or instrumental ADLs  Has results of recent kidney function tests  Has a history of seizure  Request is for AUBAGIO (teriflunomide):  Has results of recent liver function tests							
☐ Request is for GILENYA (fingolimod):         ☐ Has a comorbid heart condition – describe:         ☐ Experienced any of the following in the past 6 months:         ☐ Myocardial infarction       ☐ Transient ischemic attack         ☐ Unstable angina       ☐ Decompensated heart failure         ☐ Stroke       ☐ Class III/IV heart failure							
Request is for KESIMPTA (ofatumumab):  Does not have active hepatitis B virus infection							
Request is for LEMTRADA (alemtuzumab): Dates of previous treatment course(s):							
Request is for MAVENCLAD (cladribine): Dates of previous treatment course(s):							





Has results of a recent lymphocyte count							
Request is for MAYZENT (siponimod):  Has been tested for CYP2C9 variants to determine CYP2C9 genotype							
Has a comorbid heart condition – describe:							
Experienced any of the following in the past 6 months:							
Myocardial infarction Transient ischemic attack							
☐ Unstable angina ☐ Decompensated heart failure							
☐Stroke ☐Class III/IV heart failure							
Request is for OCREVUS (ocrelizumab):							
☐ Does not have active hepatitis B virus infection							
RENEWAL requests							
Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.							
For AMPYRA/DALFAMPRIDINE:							
Experienced an improvement in motor function since starting the requested medication							
☐ Has a history of seizure							
For all MS drugs OTHER THAN Ampyra/dalfampridine:							
Has a relapsing form of MS and experienced improvement or stabilization of the MS disease course since starting the requested medication							
Has primary progressive MS and continues to benefit from the requested medication							
Request is for AUBAGIO (teriflunomide):							
☐ Has results of recent liver function tests							
Request is for GILENYA (fingolimod):							
Has a comorbid heart condition – describe:							
Experienced any of the following in the past 6 months:							
Myocardial infarction Transient ischemic attack							
Unstable angina Decompensated heart failure							
Stroke Class III/IV heart failure							
Request is for KESIMPTA (ofatumumab):							
Does not have active hepatitis B virus infection							
Request is for LEMTRADA (alemtuzumab): Dates of previous treatment course:							
Request is for MAVENCLAD (cladribine): Dates of previous treatment course(s):							
Has results of a recent lymphocyte count							
Request is for MAYZENT (siponimod):							
Has a comorbid heart condition – describe:							
Experienced any of the following in the past 6 months:							
Myocardial infarction Transient ischemic attack							
Unstable angina Decompensated heart failure							
☐ Stroke ☐ Class III/IV heart failure							
Request is for OCREVUS (ocrelizumab):							
Does not have active hepatitis B virus infection							
PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO	D DHS - PHARMACY DIVISION						
Prescriber Signature	Date.						

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